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# Health Care Financing in Ethiopia: Implications on Access to Essential Medicines

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## ABSTRACT

**Background:** The Ethiopian health care system is under tremendous reform. One of the issues high on the agenda is health care financing. In an effort to protect citizens from catastrophic effects of the clearly high share of out-of-pocket expenditure, the government is currently working to introduce health insurance. **Objective:** This article aims to highlight the components of the Ethiopian health care financing reform and discuss its implications on access to essential medicines. **Methods:** A desk review of government policy documents and proclamations was done. Moreover, a review of the scientific literature was done via PubMed and search of other local journals not indexed in PubMed. **Results:** Revenue retention by health facilities, systematizing the fee waiver system, standardizing exemption services, outsourcing of nonclinical services, user fee setting and revision, initiation of compulsory health insurance (community-based health insurance and social health insurance), establishment of a private

wing in public hospitals, and health facility autonomy were the main components of the health care financing reform in Ethiopia. Although limited, the evidence shows that there is increased health care utilization, access to medicines, and quality of services as a result of the reforms. **Conclusions:** Encouraging progress has been made in the implementation of health care financing reforms in Ethiopia. However, there is shortage of evidence on the effect of the health care financing reforms on access to essential medicines in the country. Thus, a clear need exists for well-organized research on the issue.

**Keywords:** access, essential medicines, Ethiopia, health care financing, insurance.

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## Introduction

The right to the enjoyment of the highest attainable standard of physical and mental health is considered a fundamental human right. Internationally, the right to health was first articulated in the 1946 Constitution of the World Health Organization. The most authoritative interpretation of the right to health is outlined in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which has been ratified by approximately 150 countries including Ethiopia [1–3].

To realize this right to health, countries are required to ensure availability; nondiscriminating physical, economic, and informational accessibility; cultural and ethical acceptability; and quality of health care [4]. Generally, health services, goods, and facilities must be provided to all without any discrimination to guarantee that everyone's right to health is observed [3].

Ensuring economic access to health care is an essential element of the right to health [5]. This means, that this fundamental human right cannot be observed in the absence of effective financial protection mechanisms for health care expenditures. This is because the absence of such mechanisms has

enormous economic, psychosocial, and medical consequences. For example, out-of-pocket expenditure on health care is known to cause psychological stress on patients and their family. It also aggravates poverty in an already constrained household and leads to severe medical consequences because patients might forgo vital treatment because of unaffordability. Because it consumes the largest portion of households' health-related expenditure, out-of-pocket expenditure on medicines will have the highest effect, especially on poor households [6–10].

Looking at the situation in Ethiopia, the government is in the last phase of implementing a 20-year Health Sector Development Program since 1996–1997 with the objective of improving the country's health status. So far, remarkable progress had been made, especially in the area of increasing the number of health care facilities and decentralization of the health system [11,12].

However, the progress made in the health care financing system is a little slow. The Ethiopian health care system still suffers from limited availability of health resources, overreliance on out-of-pocket payments, and inefficient and inequitable use of resources, which limit universal coverage of health care. The health sector is generally underfinanced by both global and

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regional standards and is hugely dependent on donors and direct payment by households, contributing about 40% and 37% of the national health expenditure, respectively [12,13]. As an essential component of health care, drug financing is no exception, with households' out-of-pocket expenditure accounting for 47% of the total drug expenditure [14].

In an effort to reduce such limitations in the health care financing system, the Ethiopian government has been implementing different reforms. In 1998, the Federal Ministry of Health (FMOH) developed a health care financing strategy that became a very important policy document for the introduction of health financing reforms. Although a little slow, different regional states of the country started implementing reforms following this strategy. In May 2008, the health insurance strategy was developed by the FMOH. As a result, the government is in the process of initiating health insurance schemes: social health insurance (SHI) for the formal sector and community-based health insurance (CBHI) for citizens in the informal sector (people who are self-employed and a private sector employer with fewer than 10 employees) and agriculture. Currently, the legal and procedural aspects of the SHI system are being instituted, whereas the CBHI system is in its pilot phase of implementation [15,16].

On the face of such reforms, the importance of discussions on their implications cannot be overlooked. The implications of these reforms on accessibility of essential medicines to the Ethiopian population is particularly relevant because medicines take a large share of health care expenditure. This review therefore describes the components of the health care financing reform in Ethiopia, with particular emphasis on implications of the reforms on access to essential medicines in the country.

## Methods

A desk review of government policy documents, guidelines, and manuals from the FMOH was done. Moreover, a PubMed search was conducted on the basis of the following key words: health care financing, drug financing, Ethiopia, health insurance, access to essential medicines. The same key words were used to conduct the search in local journals, which were not indexed in PubMed. No restriction was placed on the date of publication, and all articles related to the issue of health care financing in Ethiopia were reviewed.

## Results

A total of three proclamations by the house of peoples' representatives and the council of ministers of the Federal Democratic Republic of Ethiopia, four manuals and guidelines, six evaluation documents by the FMOH and international organizations, and eight research articles published in peer-reviewed local and international journals were found on the issue of health care financing and access to essential medicines in Ethiopia. The author reviewed all the articles.

The main components of the health care reform that had been implemented by the different regional states of the country are as follows: revenue retention for health service quality improvements in the facility rather than the old system of channeling all revenue to the treasury; systematizing the fee waiver system for the poor; standardizing exemption services; outsourcing of non-clinical services in public hospitals; user fee setting and revision; initiation of health insurance; establishment of a private wing in public hospitals; and health facility autonomy through the establishment of governing bodies [15,17].

Since the institution of the health care financing strategy in 1998, user fees were seen to have increased in many parts of the

country. Until recently, the fee waiver system was characterized by ineffectiveness in specifically targeting the poor, incompleteness of coverage of services, and lack of proper documentation [18–20]. Although some reports suggest betterment of services with user fees, there is an apparent “crowding out effect” of fee increment by public health facilities, especially on the poor segments of the society in the absence of protective mechanisms [19–21].

Even though per capita health expenditure in Ethiopia increased from US \$7.14 in 2005 to US \$16.1 in 2007–2008, households are still burdened with out-of-pocket expenditures at the time they need health care [12]. The major mode of financing the public health sector has thus far been through budget allocation of revenue mobilized from the general tax and donor support [16,21,22].

The country's expenditure on drugs had been increasing by an average of around 28% annually. The per capita government expenditure on drugs was only 32 birr or US \$3.80 in 2005–2006 and households' out-of-pocket payment was 47% of the total drug expenditure. The fee waiver system did not safeguard patients against having to pay for medicines because of the unavailability of drugs in public health facilities. Moreover, the share of employer-provided drug insurance was only 0.2% of the total drug expenditure in 2005–2006 [14,23].

It was in 2008 that the Ethiopian government issued a health insurance strategy with the aim of achieving universal health service coverage in the country. While maintaining the traditional health financing mechanisms from sources such as the general tax system, development partners, and other alternative sources, the strategy calls for the mobilization of additional resources to the health sector and enhance equity in health service delivery by making health insurance compulsory to both formal and nonformal sectors. Accordingly, the health insurance strategy prescribes compulsory SHI, CBHI, and private health insurance schemes for different parts of the society [16].

The proclamation that provided for the SHI scheme was issued on August 2010, and the SHI agency was established accountable to the ministry of health [24]. Although the implementation of the scheme has been postponed to July 2014, members of the scheme will be pensioners and employees of a public office, a public enterprise, or any person who employs at least 10 employees with the exception of the defense forces. The sources of finance for this scheme are contributions by employees/pensioners and employers, investment income, and other related sources. Members and their families (spouse and children) will be beneficiaries of this scheme [25].

According to a November 2012 council of ministers regulation, any beneficiary of the SHI scheme shall have the right to access inpatient, outpatient, delivery, and surgical services. The scheme will also cover diagnostic services and generic drugs included in the agency's drug list, which is currently under preparation. However, the following services are not covered: any treatment outside Ethiopia; treatment of injuries resulting from natural disasters, social unrest, epidemics, and high-risk sports; problems related to drug abuse or addiction; periodic medical checkup unrelated to illness; occupational injuries, traffic accidents, and other injuries covered by other laws; cosmetic surgeries; organ transplants; dialysis except in case of acute renal failure; eye glasses and contact lenses; in vitro fertilization; hip replacement; dentures, crowns, bridges, implants, and root canal treatments except those required because of infections; and provision of hearing aids and those services that are anyway provided to patients free of charge. Solidarity-based contributions are adapted. Accordingly, each member of the SHI scheme is supposed to contribute 3% of the monthly salary if the person is an employee of the formal sector or 1% of the pension if he or she is a pensioner. The employer will contribute the other 3% of the

employee's salary. For pensioners, the government will cover the other 1% of the pension. The agency will require 5% co-payment for any outpatient visit, and the member will be required to cover 50% of the cost if he or she chooses to bypass the referral system except in emergencies [26].

However, CBHI schemes are to be established at the woreda and kebele level and are subsidized by the government. The scheme was bound to be implemented in two phases, pilot and scale up. It is in the pilot phase of implementation in 13 districts since 2011. Starting in the year 2013–2014, the CBHI scheme is expected to be scaled-up covering about 40% of the population by the end of the 2014–2015 fiscal year [27].

The CBHI system is based on membership on a household level, and all the members of the household are beneficiaries of the scheme. The premiums could be different in different kebeles and are decided depending on the ability of the community to pay and will be dependent on the number of members of the household. The scheme covers expenses for outpatient and inpatient services, surgery, and medicines. Generally, the services that are covered and those that are not are similar to those of the SHI scheme [28].

In a little more than a year's time after its pilot implementation, the CBHI scheme uptake had reached an impressive 45.5% of target households and studies show that there is a very high demand for the scheme [29]. Different administrative reports indicate that implementation of the reforms increased the availability of essential medicines, diagnostic capacity of health facilities, accessibility of health care to the poor, and quality of care [15,30]. There is very limited evidence, however, of these achievements in peer-reviewed scientific journals. Evaluations of the progress of the health care financing reform praised the increased availability of essential medicines due to better health facility autonomy to use the retained revenue to purchase medicines [31,32]. In contrast, there are cases in which beneficiaries of the fee waiver system complain of shortage of medicines in the health facilities, exposing them to financial burdens due to buying medicines from expensive private sources [33].

## Discussion

Majority of the evidence found in this review is based on regulations and other administrative documents. There was very limited evidence of the status and achievements of health care financing reforms in Ethiopia in peer-reviewed scientific journals. Generally, the reviewed sources showed that the Ethiopian society is highly exposed to increasing user fees for health care services and adverse effects of out-of-pocket expenditures for health care. Risk protection systems are at their level of infancy in Ethiopia [16,18–20,34].

The annual per capita health care expenditure of US \$16.1 in 2007–2008 by the government is very low compared with that in other parts of the world. It is incomparable relative to the US \$225 in upper middle-income countries and US \$2500 in high-income countries [35]. Moreover, the per capita government drug expenditure of only 32 birr or US \$3.80 in 2005–2006 was only 45% of the average per capita for low-income countries at the time [14]. The reliance of the financing system on tax revenue, donor financing, and households' out-of-pocket expenditure has proven to be unsustainable.

Although limited, the evidence shows that a significant amount of fund can be mobilized using community health insurance schemes. On the basis of willingness-to-pay studies, some researchers estimated that the amount of fund that can be mobilized using CBHI systems could be up to three times higher than the recurrent budget allocated by the government for the

health sector. This will ensure better access to health care with minimal financial hardships [20,36].

Generally, limited data exist on the effects of financing reforms on access to essential medicines in different parts of Ethiopia. The already available ones focus on general health-related effects and are largely managerial supervision reports. This paucity of published evidence on the effect of health insurance on improving the accessibility to medicines is also the case in the rest of the world. Many of the already available publications are criticized for using weak study designs, and there are conflicting results by different authors. However, the reports generally suggest that accessibility to medicines depends more on the functioning of the public health care system and quality of services than on the availability of health insurance. Moreover, the level of comprehensiveness of the medicines benefit package affects the protective effect of health insurance on out-of-pocket expenditure for medicines [37–42]. Thus, the need for well-designed studies on the subject is of paramount significance [40,43].

An implication of the induction of the social health insurance system in Ethiopia could be a surge of very high health care utilization and creation of a big gap of supply of medicines and services as witnessed in other parts of the world [44]. Moreover, the potential negative effects of the institution of health insurance on the rational use of medicines seen in some countries should not be overlooked [45].

## Conclusions

Although a little slow, the progress made in the implementation of health care financing reforms in Ethiopia is encouraging. The government's effort to institute health insurance schemes should be supported by the incorporation of important principles of pharmacoeconomics and health technology assessment. Generally, there is no clear evidence on the effect of health care financing reforms on access to essential medicines in Ethiopia. This could be because health care financing reforms, especially health insurance, are a new phenomenon for the country's health care system. Thus, there is a clear need for well-organized research on the issue.

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